

Application for Assistance

- Application may ONLY be completed by REFERRING PROFESSIONAL.
- To expedite case review, please answer COMPLETELY.
- Please type or print clearly.
- Fax this completed form with a cover sheet to:
Krystal (303) 541-9712.
- Q & A: (303) 484-2126



FOR OFFICE USE ONLY	
Case # _____	_____
Date Received _____	_____
Screener: _____	_____
Check sent to: _____	_____
(Address) _____	_____
_____	_____
Check #: _____	_____

<p>CONFIDENTIAL INFORMATION</p>
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Referring Agency					
Agency Name:		Caseworker:		Date of Application:	
Address:		City/State/Zip:		Office Phone/ext (or Pager #):	
Fax #:	Email Address:		Best time(s) to contact you if necessary:		
I certify that _____ has a mild to moderate traumatic brain injury. (Applicant's name)					
Signature of referring practitioner: _____		(Signature)		_____ (Print name)	
Applicant					
Name:		DOB:	Social Security #:		Telephone:
Address:			Apt. #:	Years there: <input type="checkbox"/> Own <input type="checkbox"/> Rent	
City/State/Zip:			Email Address:		
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law How long? <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Spouse Name:		DOB:	Social Security #:
Are there children in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No		Ages of children: _____		Is the applicant responsible for the children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Voluntary Information Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Ethnicity: <input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other					
Specific Assistance Requested					
Rent/Mortgage Payment: \$					
Food: \$			Utilities: \$		
Amount you are requesting: \$					

Other Sources Contact for Co-Payment

Please list all organizations contacted whether request was approved, denied, or is pending. Include neighbors, service organizations, vendors, doctor, dentist, churches, extended family members, etc.

Organization:	Amount Requested:	Amount Pledged:	Date:
Organization:	Amount Requested:	Amount Pledged:	Date:

Family Member Resources

Can any family members help the applicant at this time of need? Please explain.

Applicant's Own Resources

Employed Unemployed

Name of Employer:	Address:	Phone:	Type of Business:
Position Held:	How Long?	Monthly Gross Income: \$	Monthly Net Income: \$

Please provide any information which may be helpful in understanding unusual deductions, job situation, salary, etc.

Approximate Monthly Household Income: \$

Approximate Monthly Household Expense: \$

If you obtain Social Security, SSDI, SSI, AFDC, Pell Grants, Worker's Comp, Disability, etc., please list the amount: \$

Do you currently get Food Stamp Assistance?

YES

NO

General Information

Please use this space to describe, as fully as possible, any additional information related to this present situation of need. Attach any additional information or documentation as necessary to expedite a prompt review and deliberation of this application, including brain injury status.

I, the applicant, am aware that the application process can take a considerable amount of time. I am also aware that funds might not be available. Note: Brain Injury Hope Foundation will notify applicants within 2 weeks by phone/mail/email when the application has been received.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
I, the applicant, give permission for the release of this information to another agency for possible co-payment.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has the applicant previously applied to the Brain Injury Hope Foundation for assistance?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
The applicant and referring agency agree to defend, indemnify, and hold the Brain Injury Hope Foundation harmless from any and all claims, disputes, liabilities, or causes of action arising out of the agreement to provide assistance, or the providing of assistance, or arising out of services and goods sold or provided to recipients of assistance to the Brain Injury Hope Foundation .			
I, the applicant, certify that all the above information is accurate and complete to the best of my knowledge. I also agree to use this money, if granted, for food, rent, security deposits, or utilities.			
Signature of applicant/client:		Date:	
Signature of parent signing for minor:		Date:	
Signature of person referring:		Date:	
For Official Use Only			
Date presented:	Decision:		
Date re-presented:	Decision:		
Check #:	Check amount:	Date:	
Check #:	Check amount:	Date:	

Brain Injury Hope Foundation

P.O. Box 1319 Boulder, CO 80306 (303) 484-2126 www.BrainInjuryHopeFoundation.org